STATE OF CONNECTICUT

OFFICE OF HEALTH STRATEGY

STATE INNOVATION MODEL PROGRAM MANAGEMENT OFFICE

REQUEST FOR APPLICATIONS (RFA) FOR PREVENTION SERVICE INITIATIVE – FOR COMMUNITY BASED ORGANIZATIONS

FIRST Addendum

RELEASE DATE – 02-28-2018

REMINDER: THE DEADLINE FOR THE PREVENTION SERVICE INITATIVE – FOR COMMUNITY BASED ORGANIZATIONS IS FRIDAY, MARCH 9, 2018 AT 3PM.

On February 16, 2018, two webinars were held regarding the Prevention Service Initiative. The first webinar was targeted to healthcare organizations, and the second to Community Based Organizations. The full transcripts from the CBO webinar is below. The presentation slides will be posted here: http://www.healthreform.ct.gov. Additionally, written responses to the questions from the webinar, as well as written questions received via email, are also below.

1. **Question: For the SIM Prevention Service Initiative (PSI), which specific diabetes management programs will be supported by the grant? The Stanford Diabetes Management Program? The YMCA DPP Program? Any others programs?**

   Response: CBOs must currently provide a chronic disease self-management program with a focus on asthma or diabetes self-management. The applicant may choose a program other than the Stanford *Diabetes Self-Management Program* (DSMP) as long as it is evidence-based. The Prevention Service Initiative does not support DPP or other diabetes prevention programs at this time.

2. **Question: We are an FQHC and we currently have a robust diabetes prevention program for which we have created a Business Plan and sustainability model. What would DPH require from us in order to make our DPP eligible for the PSI opportunity for CBOs? Would creating a separate legal entity, such as an LLC, be sufficient? If the answer is yes to this last question, by what date would the LLC need to be in existence? Obviously this is not possible by the deadline for application submission.**

   Response: As noted on page 8 of the solicitation, the State is promoting evidence-based chronic disease self-management program with a focus on asthma self-management and home environmental remediation or diabetes self-management and delivered in community settings. These services were prioritized based in part on the following criteria:

   - proven positive impact on health outcomes and health disparities,
   - ability to improve performance on quality of care measures present in shared savings program arrangements, and
   - potential to provide a financial return on investment to the healthcare organization.

   Although evidence-based diabetes prevention programs meet the first criterion, they do not meet the second or third criteria. Medicare, Medicaid and commercial shared savings programs do not have scorecard measures related to diabetes prevention and the impact of these programs is not likely to generate savings to the provider under the terms of such arrangements. As such, diabetes prevention would not be sustainable in the current market. The State has begun planning for the Health Enhancement Community initiative, which is intended to address this issue by creating a savings opportunity for providers when new cases of diabetes are prevented.

With respect to the question of forming an LLC, this RFP is focused on CBOs that are not healthcare organizations because CBOs generally do not have the business competencies to effectively market healthcare related services. After the close of this procurement, the State would be receptive to learning more about the services provided by FQHCs and whether there is a role that the State can serve in enabling the use of these services as a shared community resource.

3. **Question**: **Would a lead community based organization be eligible to apply on behalf of a collective?**

   Response: A CBO may apply for this opportunity if it is proposing to provide the required chronic-illness self-management services to healthcare organizations by means of sub-contracts with CBOs that are currently providing such services.

4. **Question: Is the Pomperaug Health District located less than 9.6 miles from New Haven ineligible to apply and be considered for this SIM CBO Grant because of the stated territorial requirement? (I have attached a google map for your reference.) I do request that if the SIM Group makes any changes to this grant based on the request of the Fair Haven FQHC that you recall this grant opportunity, rework it and re advertise?**

   Response: The goal of this project is to build contractual relationships between Community Based Organizations and healthcare organizations that have shared savings arrangements with Medicaid, Medicare or commercial payers. Under these shared savings arrangements, the healthcare organizations are rewarded financially for delivering better healthcare outcomes to their attributed populations at a lower cost. To this end, SIM PSI is seeking to engage CBOs that serve regions of Connecticut where a substantial concentration of patients are receiving services from healthcare organizations in shared savings arrangements.

   Most of the healthcare organizations participating in shared savings arrangements with Medicaid (PCMH+) and other payers are concentrated in the New Haven, Bridgeport and Middletown areas. The Pomperaug Health District does not serve any of the towns that comprise the greater New Haven area and as such is not eligible to apply.

   Depending on the availability of funds, the State may consider adding additional demonstration areas after the Department of Social Services completes its procurement for participants in Wave 2 of PCMH+. At that time, other regions may be found to have a sufficient concentration of patients that are receiving services from healthcare organizations participating in in shared savings arrangements with Medicaid (PCMH+) and other payers.

5. **Question**: **I have one basic question related to this, as follows:**

   Background

   The eligibility requirements are described in the RFP as follows:

   Community based organizations must also meet the following requirements:
   - Must be currently providing in Connecticut the services that will be a focus of this model, as described in **Section 4.2 Priority Services for Model Demonstration**;
   - Must have the capacity to establish or extend services to residents in at least one of the three target communities, as described below.

   HHC Experience

   - The Hispanic Health Council developed a rigorous CHW protocol for diabetes management and implemented it through a randomized controlled trial (called DIALBEST) that indicated outstanding success. The model included training manuals for CHWs and patients, and care coordination protocols. Results have been published and widely disseminated.
   - When the study ended, delivery of services ended. However, it is highly likely that HHC will initiate delivery of services according to the DIALBEST model with an FQHC patient population beginning in April.
   - In addition, HHC is currently delivering CHW services in the areas of: prenatal and infant care, breastfeeding promotion and support, parenting support and education, cancer prevention, cancer

patient navigation, domestic violence, supported parenting, supported employment for Latinos with serious mental illness, nutrition education and HIV support, among others.

- HHC's Breastfeeding: Heritage and Pride Program, also evaluated through a RCT and nationally recognized, has just been funded to extend its reach to 40 OBGYN hospitals within a national hospital system.
- HHC has been deeply involved in informing CHW policy development, through the convening of two symposia with a third in planning process, development with a panel of national experts of a policy brief on CHWs and SDOH, and participation in two SIM committees related to CHW policy.

In light of the experience highlighted above and anticipated initiation of the delivery of DIALBEST services in the very near future, would it be possible for an exception to be made regarding the requirement highlighted in yellow above? Could HHC be considered as eligible despite the fact that these specific services are not currently being delivered by the organization? If such an exception were possible, how would HHC indicate this in the body of the proposal?

Response: The State will permit applications from existing CBOs that have provided qualified services in the past three years and that can demonstrate that they would be able to deploy these services in the demonstration areas within the proposed implementation timetable for this solicitation. The applicant should detail their experience providing the proposed service, the evidence supporting the proposed service, and the plan for deploying the service in one of the demonstration areas.

6. **Question: I see that the RFA specifically mentions Bridgeport and New Haven. I and looking to partner with Griffin Hospital in Derby (greater New Haven) concentrating on asthma in Shelton, Derby, Ansonia, Seymour, Beacon Falls. Would a proposal from us be considered under the geographic area requirement?**

   Response: Please see response to question #4 above. Shelton, Derby, Ansonia, Seymour, and Beacon Falls are not among the towns that comprise the greater New Haven area; however, they are part of the Bridgeport-Stamford NECTA and contain a significant concentration of patients receiving services from healthcare organizations in shared savings arrangements with Medicaid (PCMH+) and other payers. Accordingly, your organization is eligible to submit an application.

7. **Question: Can you define the surrounding towns you would accept for service in the Middletown area? We serve as the Putting on Airs Region 2 coordinator and would like to take advantage of this RFP if our maps align.**

   Response: Please see response to question #4 above. Wethersfield, Rocky Hill, Berlin, and Newington are not among the towns that comprise the greater Middletown area and as such a CBO focusing on this service area is not eligible to apply.

   Depending on the availability of funds, the State may consider adding additional demonstration areas after the Department of Social Services completes its procurement for participants in Wave 2 of PCMH+. At that time, other regions may be found to have a sufficient concentration of patients that are receiving services from healthcare organizations participating in in shared savings arrangements with Medicaid (PCMH+) and other payers.

8. **Question: We do not currently deliver the diabetes management program, but would like to, would this help us bring the program to the health department? Or do we need an already existing program in place. Are these reimbursable services?**

   Response: The Prevention Service Initiative focuses on linking CBOs that already provide, or have recently provided, chronic illness self- management programs with healthcare organizations. It is not designed to develop new programs. If the inquirer meets the service provision requirement, as modified in response to question #5, the inquirer may be eligible to submit an application.

9. **Question: The initial award is for $20,000. After three months, based on eligibility, a CBO could apply for an additional $30,000. Is there like a set criteria for that?**

   Response: After three months of receiving technical assistance, CBOs will be eligible, contingent upon the completion of a Prevention Service Business Plan, to apply for an additional $30,000 of funding. This may fund, for example, information technology, personnel needed for additional demand until contract with healthcare organization is underway, consultation services to ensure Board of Directors approves the new

strategy, legal costs associated with contract development, and other. The initial technical assistance will help the CBO in determining the specific funding needs related to this initiative. This funding is not guaranteed and is based on the progress of the CBO in establishing a formal arrangement with a healthcare organization.

10. **Question: Does our local health department have to be in one of the cities to apply? (We are located in Branford and serve Branford, East Haven and North Branford)**

    Response: The selected CBO for the PSI project does not need to be physically located in the target areas but need to have the ability to provide services to patients attributed to healthcare providers in the priority areas.

11. **Question: We do serve folks for the city (New Haven) however mostly for things such as flu vaccine at this time. Does that make a difference?**

    Response: As noted on page 8 of the solicitation, the State is promoting evidence-based chronic disease self-management program with a focus on asthma self-management and home environmental remediation or diabetes self-management and delivered in community settings. Although flu vaccination has a proven positive impact on health outcomes, it does not has an immediate impact on cost reduction related to quality care of chronic disease.

12. **Question: Do we have to include New Haven in our proposal?**

    Response: The towns of Branford, East Haven and North Branford are among the towns that comprise the greater New Haven area and as such they contain a significant concentration of patients receiving services from healthcare organizations in shared savings arrangements with Medicaid (PCMH+) and other payers. Accordingly, your organization is eligible to submit an application.

13. **Question: What are the criteria to meet the 'readiness to work with a PSI Technical Assistance consultant'?**

    Response: The criteria to for readiness to work with the TA provider is essentially a commitment to fulfill the Participation Requirements found in **Section 4.3** on page 8 of the RFA.

14. **Question: How will we know which healthcare providers participate in value-based payment?**

    Response: The DSS periodically publishes in its website updates on PCMH+ Participating Entities.

Prevention Service Initiative Webinar: Community Based Organizations
February 16, 2018
1:45 pm CT

Coordinator: Welcome and thank you for standing by. At this time, all participants are in a listen-only mode. During the Q&A session if you'd like to ask a question, press Star 1 on your phone. Today's call is being recorded. If you have any objections, please disconnect at this time. Now I'd like to turn the call of to Miss (Trish Torruella). Ma'am you may begin.

(Trish Torruella): Thank you (Ted). Good afternoon everyone. And thank you for joining us on this webinar. The SIM Prevention Service Initiative is a collaboration among the Connecticut Health - Office of Health Strategy, the Department of Public Health, and I'm happy to say now, Health Management Associates. HMA, as we refer to them, is a national consulting firm with tremendous breadth and depth of knowledge in states across the country as well as Connecticut. They touch on many different topics but some of the ones that we will be focusing on are the current delivery system reform, the importance of linkages and networks. And what HMA will be doing with us is providing a technical assistance process over 18 months. To help healthcare organizations and CBOs to address linkage models in the community.

So I am (Trish Torruella). I'm a Project Consultant with SIM in the Department of Public Health Population Health. And with me are (Faina Dookh) who is a Project Manager with the Office of Health Strategy State Innovation Model and from HMA we have (Karen Scott) who is a Principal with HMA. And (Karen) would you introduce some of the other members of your team that are joining us today?

(Karen Scott): Sure, I'm happy to. And also joining me is (Katy Secon) a Consultant from (unintelligible) as well. And (Kathy) has an extensive background in working with healthcare organizations and quality of care.

(Trish Torruella): Thank you (Karen). And one of the things that I wanted to do from the very beginning is to make sure to clarify that when we say healthcare organizations, we're talking about Advanced Networks in Federally Qualified Health Centers with attributed patients in the Bridgeport, New Haven, or Middletown regions. We have found that ANFQHC gets to be a bit cumbersome but wanted to make sure that we had clarified that from the outset.

So with that, I'm going to do a very brief review of the agenda. You will be hearing from all of us, (Kathy), (Karen), (Faina) and myself. We have designed an agenda to provide context on the Connecticut state innovation model as well as the prevention service initiative. In addition, with HMA staff team members, we will talk about the linkage model's success factors in evidence-based preventive care. So that (Kathy) and (Karen) will be going in more depth with you about what the model is, what the technical assistance looks like.

And then finally we will touch briefly on the RFA which I hope you have had a chance to look at. So what we will do on this call, on this webinar is to touch on the timeline, the important dates. And then we will tell you a little bit more about asking questions in writing. But for you know that as the operators said what we will do is we will hold questions until the end of the actual presentation and then open it up for questions from anyone on the line.

And with that, I think we go to (Faina).

(Faina Dookh): Great, thanks (Trish). So just provide some context, the prevention service initiative is one of the latest state innovation model efforts. And Connecticut is one of several states participating in the State Innovation Model or SIM initiative over four years and it allows Connecticut to test really a variety of innovating strategies and our hope to drive towards our four aims. That people in Connecticut are healthier. That we have better healthcare. That we move towards health equity and that we reduce healthcare spending which is rising and projected to continue to rise.

And we work closely with a lot of healthcare providers across the state, likely many on this call. And we're really excited to launch this latest SIM effort the preventive service initiative. This initiative builds on SIMs push towards value-based payments and towards new ways of delivering care. It builds on our efforts to provide support to healthcare organizations as they try to figure out to truly transform care and how to succeed in these new alternative payment models. The preventive service initiative in combination with our other SIM efforts supports healthcare organizations as they work to perform consistently on quality measures like emergency department use, diabetes control. We're helping healthcare organizations focus on smarter spending and value not volume. And to integrate with the community so that we're able to address all of a person's needs that impact their heath and their asthma and their diabetes including molds, mice infestations, access to nutritious diet and other factors that are the focus of the prevention service initiative.

And with that I'll turn it back to (Trish).

(Trish Torruella): So as you saw in the previous slide and heard from (Faina). Population health is one of the five primary drivers that supports SIM aims; healthier people, better care, smarter spending and health equity. And in this particular slide, we are addressing directly the factors within population health that we are looking to impact. So on the left-hand side of the slide, you certainly see social determinants of health, community place care. The emphasis on asthma and diabetes self-management. The idea of eliminating health disparities and certainly reducing emergency department and inpatient hospital use.

This, I have to say, is my favorite slide because I think it illustrates the multiple interrelated factors that impact population health. And in Connecticut with the PSI demonstration, we will be focusing specifically on diabetes and asthma self-management and in the three regions that I mentioned earlier. So back to (Faina).

(Faina Dookh): So we know that for the people in our community, making sure that their diabetes and their asthma is effectively managed. It really requires an all-hands on deck approach. It requires the person's commitment. It requires our healthcare organization. It requires our community-based organizations and it requires the local health department. And today in Connecticut what we're hearing is that people are really having a hard time smoothly moving between all these organizations to get in what they need to effectively manage their chronic conditions.

Primarily, this initiative aims to create new pathways between healthcare and our community organizations. To create a consistent avenue for patients to access resources in the community to help them with their diabetes and their asthma. Healthier organizations, as you know, are more and more accountable to quality measures and to spending and it matters more and more that there is this connection to the community. And we know that health depends on a lot more than what happens just inside of the four walls of the doctor's office.

Healthcare organizations are faced with a choice of building themselves or buying some of the needed services that patients need that they don't traditionally offer like home visits, mold

remediation, help with buying food, etc. The preventive service initiative builds on a promising experience from across the country that is showing that when healthier organizations choose to buy existing services like these from established community organizations, everyone gains; the healthcare provider, the community organization and especially the patient.

So with that I'll turn it over to (Karen Scott) with HMA.

(Karen Scott): Great, thank you (Faina). And as (Faina) said we're really building this initiative around emerging evidence-based practices both around the importance of collaboration, partnership and linkages between healthcare organizations and community-based organizations. And also around highly effective community-based preventive services with respect to achieving improved clinical outcomes for our populations as well as improving appropriate use of healthcare services and better managing use of emergency (unintelligible).

The community-based preventive services that particularly interested in expanding through this initiative include: focus on effective asthma strategies with include home visits, education for (unintelligible) caregivers, managing the environment and mitigating environmental triggers. For diabetes, a key focus will be in implementing and expanding the diabetes self-management and education programs Which again, have been shown to be effective in improving (unintelligible) control, patient adherence and reducing the need for emergency department in hospital and inpatient hospital care.

To just go back to the center of the slide for a moment, I want to just reiterate (Faina)'s focus on the linkage. And some real focus in this particular project is to test this idea of contracting between two organizations and community-based organizations as a way of focusing on the long-term change to the system and sustainability could be to ensure these services are provided to a broad population at risk.

Next slide. (Unintelligible) to why you as healthcare organizations might participate. And how to make sure we're building something that will provide value to you in a number of ways. So firstly, this initiative is really designed to support success in (unintelligible) models of care. And within the value-based payment model, certainly measures related, (unintelligible) measures related to emergency department use, inpatient care, but also medication management and disease control for asthma and diabetes will very much be the kinds of (unintelligible) that you as providers will be held accountable for. And setting goals in order to be successful in the (unintelligible) payment world.

Again, these are - we want to focus on interventions that have been shown to improve outcomes, so they will support your quality scores (unintelligible) and as you'll hear more about later in the presentation (unintelligible) initiative there is some funding (unintelligible) to get started in developing these contracts. But we also think beyond value-based payment, this is really an opportunity to think about - think broadly about how to best serve a population, the full population that you're serving. And what the opportunity is to leverage what some of the community-based organizations can bring to your patients as well.

For many healthcare organizations, partnering with CBOs is a way to engage some of the hardest to reach patients within your population. It's an - it provides a greater ability to address some of the nonclinical factors and the social determinants upheld (unintelligible) that are beyond your purview or readily or ones that are not readily available to address. The way of providing a cost-effective service in terms of the community-based services and it allows for an efficient use of your time as providers. You're able to really focus on the clinical needs of your patients when they're with you.

Next slide. In terms of the technical assistance project and the work of health management associates, we're envisioning this work as an ability to support and provide technical assistance to both the community-based organizations and the advanced network (unintelligible). We understand each organization is in a unique place and so that (unintelligible) to be very much tailored to something that's of value and helps you progress towards the ability to contract with the community-based organization.

Our interim outcomes and goals are both to have active participation in the technical assistance and by November of this year achieve at least one contract between provider and CBO. And finally, our overall outcomes and goals jointly for this program is to increase the number of patients who are being served and receiving (unintelligible) preventive services in the community. On the CBO side, support the (unintelligible) service delivery skills as needed. And on the healthcare organization side, to put your ability to improve performance on quality measures.

This is a busy slide, but to recognize that there are two streams of work going as we start this project. One stream of technical assistance for the community-based organizations and a second for the healthcare organizations to hopefully bring us to the point of the diamond in the center when we are helping you negotiate contracts which specific services. While we will work with each set of organizations participating in the initiative, we also want to make sure that we're finding time to bring you together with your colleagues, with your other healthcare organization colleagues as well as with the potential CBO partners. So that you're really jointly understanding the needs of the populations that need to be served and how you can best work together.

And (Kathy) will not talk a little bit more about that technical assistance.

(Kathy Secon): Thank you. In this slide as well as the next three that follow are intended to give you a high-level overview of what we envision as the type of services and the topics that we'll cover as the technical assistance. But I should really frame that as saying this is a starting point in all of the technical assistance will be customized for each participant based upon the needs that you identify with the most helpful for leveraging and enhancing your capacity to do this work.

But this particular slide is an example of the types of assistance we anticipate. Some areas of work based upon work that we've done across the country to -based upon the literature that we've seen. We certainly think in terms of working with the advanced network and the FQHCs that we could envision doing some work around detailing the referral processes perhaps, you know, looking at the design and reliability of some of your clinical workflows. Understanding really what the goal is for meeting the needs of your particular patient population.

Are others also getting?

(Trish Torruella): Yes, we are. (Ken) are you hearing this?

Man: (Unintelligible).

(Trish Torruella): I hope not.

(Kathy Secon): There we go. Okay, I think we've got it now.

(Trish Torruella): Oops, it's persistent.

(Kathy Secon): Yeah.

Man: (Unintelligible).

(Trish Torruella): I'm going to try. Okay, did it stop?

Woman: It stopped.

(Kathy Secon): Okay so -

(Trish Torruella): Let's -

(Kathy Secon): Let's hope that it stopped. But I was saying is, you know, we anticipate that we'll be working with you with regard in particular to the referral process, perhaps some of the clinical workflows. Population health analytics and measurement as (Karen) and (Faina) mentioned are really important. And of course, this is a collaborative project So developing, you know, the communication structures and identifying the population that most likely to benefit from this work and the metrics to really evaluate how well we're achieving those goals, you know, will be important.

And similarly as you look at the next slide, we are expecting to offer the same type of assistance to FQHCs although we anticipate that - the CBOs rather, I should say. That the CBOs will be perhaps at a different point along the spectrum with regard to any of these particular areas. But I would think particularly we might need to do a different type of work with them around some of the financial analysis. Perhaps even some of the quality improvement work. Helping them to really understand what needs to be in place with regard to the systems and the structures and metrics. So that they can help you determine or work with you to determine exactly what they can best provide your needs for your patients with regard to, you know, implementing some of the evidence-based practices and measuring some of those outcomes.

And then next slide really talks about some of the ways that we are planning to deliver the services. We know that your agenda and your day is crowded. We know you are participating in a number of different initiatives and collaboratives. And we recognize that we need to make sure that the material and the assistance that we provide to you is value-added. We'll work very hard to recognize unique needs of each group. So some of these learning sessions and webinars will be targeted to each specific participant whether that be the CBO or advanced network FQHC.

On the other hand there are going to be times where we'll have the opportunity to bring you together. This is a collaborative project and think that it's really important that you have the opportunity to build those relationships, to learn from one another and do some peer to peer mentoring and benefit from those services. And particularly to understand the needs of the target population where there are gaps in care that will help better meet those patient needs. Which entity is really best able to help deliver those services?

So the following slide really provides just a list of the different types of methods and tools that we anticipate in plugging in this work. We'll absolutely tailor tools to help meet the needs of the organizations, but we do have a number of structured assessments that we have used in other projects that will give us a starting point whether that be around the gap analysis. Which will be our first sketches really an assessment of each organization to identify, you know, the patient population, and the gaps in services that can best be met by this particular initiative. The contracting readiness tool and we also have some financial forecasting tools that we can bring to bear on the project.

We also, I think, also was ultimately just wanted to make sure that we help you to achieve implementation of a model that can be used for future replication. We understand that diabetes and asthma are only two of the chronic conditions that, you know, patients have. And areas where you might want to scale this particular initiative or employ in other areas would be helpful. And so having a model to move forward is something that we will work closely with you on. And taking advantage I think of some of the data systems and registries that you currently have in place. And developing metrics that make sense to help evaluate the performance of this particular collaborative as well as each of the participants in moving forward for that.

And I think (Karen) I can turn it back over to you for some of the examples of work that we've done in other areas.

(Karen): Great, thank you (Kathy). I just very quickly want - we wanted to highlight a couple of examples of what we're thinking about and what we think is really exciting work for us to learn more about and to leverage and expand with all of you in Connecticut. The first example, an asthma program is a relationship between hospitals in Baltimore, their outpatient services and the Baltimore health department. Where a select - set of services including home visits, education for children and caregivers, as well as the environmental assessments. And addressing triggers in the environment have really led to a set of impressive outcomes in terms of decreased hospitalizations, improving medication adherence, symptom free days and increasing parent knowledge on asthma symptoms and triggers.

The strength of the program has really been built around formal communication and shared information between the healthcare organizations and the health department. A very much common set of goals and practices in terms of coordination of care employing community health workers to conduct - to be trained and conduct the home visits and sharing as well and evaluation programs. So they're both following collecting data and tracking and the results of the program as they progress. They can - so they are continuously learning from the progress of the program as well.

And the next example very briefly is one from New York. And describes a contact and relationship between several hospitals in the Bronx. And a community organization called Touch People. This is an organization that has trained members of the community to conduct their Stanford diabetes self-management program. And then engage members of the community really going into the community to identify people with diabetes who would benefit from the education program receiving referrals from the hospitals, But and then following up on those referrals by very much being on the ground in the community engaging peers to both help draw patients to the training as well as to deliver the training. And they're beginning to see some very tangible outcomes from that work.

In the past year they've enrolled over 700 participants in sites across the South Bronx. They're beginning to see members who have completed - 77% of the participants have completed all successions. They've maintained a, over the course of a year, on average a drop of .4 in their A1C. And they're seeing decreased levels of depression in that population. So linage to care and stronger supports in the community are really making a difference in the South Bronx population.

So why participate? Well again, we know that there is a lot going on in Connecticut in the delivery system and through population health activities. And that consideration of joining another project or initiative requires your careful consideration. But I hope that you'll agree that there's some exciting opportunity here. First and foremost, to make sure your patients are getting - fully getting all of the care and being able to maximize their health outcomes. But also that this is a continued way that you can be participating in redesigning the delivery system that you work in. That you can use these services to help address some of the social determinants

of health that your population is facing. And at the same time, address the potential challenges that you may be facing in terms of being able to work efficiently to serve your whole population to - as well as to prepare for reimbursement under value-based payment programs.

Next slide. And I will turn it back to (Faina) to talk about the RFA.

(Faina Dookh): So here on the screen you just - you see the basic information above the RFP that's currently out. And the application due date is March 2 and you'll see here the period of participation and the estimated award amount as well as who's eligible. And we do take questions on a rolling basis. Those questions are posted publicly as a formal addendum and when you submit your questions to me, I'll, you know, I send the link out to that website as well.

But we wanted to leave this last segment of our presentation for your questions and leave some time for discussion now.

Coordinator: The phone lines are now open for questions. If you'd like to ask a question over the phone, please press Star 1 and record your name. If you'd like to withdraw your question, press Star 2. Thank you.

(Trish Torruella): Do we have questions?

Coordinator: Not yet, however I believe a few of them are popping up here.

(Trish Torruella): Great.

Woman: (Faina) there is one question in the chat section.

Woman: I responded (unintelligible) audio.

(Trish Torruella): If you do have a question in the chat, if you wouldn't mind doing the Star 1 and asking it verbally, that would be great.

Coordinator: There's a question in the queue for (Kirsten). Your line is now open.

(Kirsten): Hi, good afternoon. Thank you for hosting the webinar. I really appreciate the comments from everybody who's on the phone. And I look forward to meeting you at some point in the next few years. My question relates to the funding for this initiative. So as a participant in patients at a medical home, we've - one, we are being asked to participate in a preventive service initiative as a contingent on our participating in PCMH Plus Wave 2. And in the PCMH Plus Wave 2 RFA there is a reference to the funding. And it talks about $100,000. Then it talks about 250,000. And we just want to make - have a question for (Faina) around what is the anticipated funding for prevention service initiative? Because in the PCMH Plus Wave 2 documentation, it had two conflicting sets of information.

(Faina Dookh): So I would first point your attention to an addendum that was released that tried to make concrete the funding available. But the funding available for the prevention service initiative for healthcare organizations is $100,000 for each healthcare organization.

(Mark Shaeffer): This is (Mark Shaeffer). If I can jump in as well. The - I think we anticipate (Kirsten) that 30,000 - a total of $60,000 of the $100,000 would be earmarked for PSI service costs. That is payments to CBOs for the service. And so the amount that an organization, advance network or FQHC is eligible for would depend on whether they have one or two CBO contracts.

The $250,000 that's referenced in the RFP is a separate supplemental award, and estimated amount for other activities, basically other opportunities will likely will not be so finely prescribed. And we anticipate putting that opportunity out sometimes in the latter part of March. And $250,000 is an estimate. Where that number ultimately lands, it may be a little higher depending on how many - how or overall cease of budget is winding out with Wave 2 participants.

(Kirsten): Great, thank you so much for the clarification.

Coordinator: And once again, if you would like to ask a question over the phone, please press Star 1 and record your name. Thank you. There's another question in the queue from (Mike). Your line is open.

(Mike Cordulo): Yes, this is (Mike Cordulo) from Children's Medical Group. And my question has to do with who would be providing home visit services through a CBO? Are we envisioning that that would involve a community health worker role? And if so, is the anticipation that the grant money to the healthcare provider - healthcare organization would be paying the CBO to provide that service?

Woman: (Mike) I just wanted to clarify your question. You're asking whether the - a community health worker would be providing the asthma home visit. And if so would the healthcare organization be paying the CBO to provide that service? Did I get that right?

(Mike Cordulo): Yes. Or how else might that be funded or reimbursed?

Woman: Your understanding is correct. The healthcare organization would be paying the CBO as part of this new contractual arrangement. And we are anticipating that community health workers will be part of the prevention service model that's delivered by the community-based organization.

(Mike Cordulo): Great, thank you.

Coordinator: There is another question in the queue from Dr. (Hunt). Your line is now open.

Dr. (Hunt): Good afternoon everybody. Can you explain that a little bit further? In the guidance that we saw in the RFP, there was a percentage in the first six months gives the CBO a percentage in the second month. And then if the ROI shows value, then there would be a third round or an expectation. Can you explain that concept? And then Number 2, is when we're looking for a CBO partner that may not already be identified at this state, how difficult will it be for a new CBO to identify themselves under the application process and move forward? And will it make this timeline for this RFP?

Woman: So (Mike) I'm going to go ahead and answer your first question first. So in terms of the actual reimbursement expectation, so the state is providing funding to help the healthcare organization to jumpstart these contracts. And we're providing 80% of the cost of the contract for the first six months and then 60% for the next six months. And the rationale here is that, you know, the healthcare organization for this to really be sustainable and for the healthcare organization to be really committed to this, we're asking them to contribute the remaining percentage so that there is that commitment and pathway to sustainability. And so after the 12-month period, the healthcare organization will make a determination based on the return on investment and impact on quality measures whether this is a good ongoing investment. We're hoping that it is.

I'm going to pause there to make sure that that clarifies it and ask you to just repeat your second question.

Dr. (Hunt): Before I repeat the second question, can you - so explain it. So 80% in the first six months, 60% in the second six months and that's out of the $100,000, correct?

Woman: No, so there's actually an addendum that I want to point you to that's on the business website that actually creates a hypothetical table for what the total contract would be and what the actual healthcare organization contribution is. And in this hypothetical example, the total healthcare organization contribution over the 12-month period is around $13,000. And it breaks out for each category what the award would be and the percentage the state would cover. And the percentage the healthcare organization would cover. And again, just contribution by the healthcare organization could be less than that if they so choose that in their contract negotiation.

Dr. (Hunt): And then the second question that I had was for an organization that is not quote unquote identified and has to submit the application process, is it realistic for them for us to work with an organization to meet this timeline?

Woman: So we have a - we currently have another procurement that's soliciting the community-based organizations with a similar timeline of the application deadline. I guess, can you clarify your question about identifying the CBO?

Dr. (Hunt): Yes, so we've been looking at community organizations and I don't know that they're officially recognized by DSS currently. And so I think they would have to undergo the process for which I think they listened to in the previous 45-minute WebEx. I - there's some concern that those organizations may not be able to meet the timeline in order to get this done. And/or understand the difficulty of being recognized. So is it a - how much will the established CBOs that are already recognized the state be preferred versus perhaps new entries?

Woman: So when you say already established or currently recognized, what do you mean by that?

Dr. (Hunt): So if you look at the (Healthy Heirs) program they're already recognized. They're somebody that we could start working with and identifying a potential relationship today. If we wanted to work with a community (Unintelligible) for example. They're going to have to submit and be identified as a CBO and go through that process of being recognized, correct?

Woman: No, so we're not asking for any recognition other than that is an existing community-based organization. And but we are limiting it to diabetes self-management program and asthma home visiting program based on, you know, the strong evidence there is on ROI impact on quality measures to date. But other than that, we're not requiring any other recognition or designation.

Dr. (Hunt): Great, thank you.

Coordinator: I'm showing no further questions at this time.

(Trish Torruella): Thank you so much (Ted). Let me ask you a question. In terms of having a little bit of time with (Karen) and (Kathy), do we need to actually go to a separate call or do we continue this one?

Coordinator: If you would like to end this current call, I can place you into the post-conference.

(Trish Torruella): That would be great.

Coordinator: Okay. This concludes today's call. Thank you for your participation. You may disconnect at this time. Speakers, please stand by.

(Trish Torruella): Thanks, (Ted).

Coordinator: You're -

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